Senate

General Assembly

File No. 214

January Session, 2007

Substitute Senate Bill No. 249

Senate, April 2, 2007

The Committee on Insurance and Real Estate reported through SEN. CRISCO of the 17th Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

AN ACT CONCERNING MEDICAL MALPRACTICE DATA REGARDING MEDICAL PROFESSIONALS.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 38a-395 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2007*):

(a) As used in this section:

(1) "Claim" means a request for indemnification filed by a **[**physician, surgeon, hospital, advanced practice registered nurse or physician assistant**]** medical professional or hospital pursuant to a professional liability policy for a loss for which a reserve amount has been established by an insurer;

(2) "Closed claim" means a claim that has been settled, or otherwise disposed of, where the insurer has made all indemnity and expense payments on the claim; **[**and**]**

(3) "Insurer" means an insurer that insures a **[**physician, surgeon,

hospital, advanced practice registered nurse or physician assistant**]** medical professional or hospital against professional liability. "Insurer" includes, but is not limited to, a captive insurer or a self-insured person; and

(4) "Medical professional" has the same meaning as provided in section 38a-976.

(b) On and after January 1, 2006, each insurer shall provide to the Insurance Commissioner a closed claim report, on such form as the commissioner prescribes, in accordance with this section. The insurer shall submit the report not later than ten days after the last day of the calendar quarter in which a claim is closed. The report shall only include information about claims settled under the laws of this state.

(c) The closed claim report shall include:

(1) Details about the insured and insurer, including: (A) The name of the insurer; (B) the professional liability insurance policy limits and whether the policy was an occurrence policy or was issued on a claims-made basis; (C) the name, address, health care provider professional license number and specialty coverage of the insured; and (D) the insured's policy number and a unique claim number.

(2) Details about the injury or loss, including: (A) The date of the injury or loss that was the basis of the claim; (B) the date the injury or loss was reported to the insurer; (C) the name of the institution or location at which the injury or loss occurred; (D) the type of injury or loss, including a severity of injury rating that corresponds with the severity of injury scale that the Insurance Commissioner shall establish based on the severity of injury scale developed by the National Association of Insurance Commissioners; and (E) the name, age and gender of any injured person covered by the claim. Any individually identifiable health information, as defined in 45 CFR 160.103, as from time to time amended, submitted pursuant to this subdivision shall be confidential. The reporting of the information is required by law. If necessary to comply with federal privacy laws, including the Health

Insurance Portability and Accountability Act of 1996, (P.L. 104-191) (HIPAA), as from time to time amended, the insured shall arrange with the insurer to release the required information.

(3) Details about the claims process, including: (A) Whether a lawsuit was filed and, if so, in which court; (B) the outcome of such lawsuit; (C) the number of other defendants, if any; (D) the stage in the process when the claim was closed; (E) the dates of the trial, if any; (F) the date of the judgment or settlement, if any; (G) whether an appeal was filed and, if so, the date filed; (H) the resolution of any appeal and the date such appeal was decided; (I) the date the claim was closed; (J) the initial indemnity and expense reserve for the claim; and (K) the final indemnity and expense reserve for the claim.

(4) Details about the amount paid on the claim, including: (A) The total amount of the initial judgment rendered by a jury or awarded by the court; (B) the total amount of the settlement if there was no judgment rendered or awarded; (C) the total amount of the settlement if the claim was settled after judgment was rendered or awarded; (D) the amount of economic damages, as defined in section 52-572h, or the insurer's estimate of the amount in the event of a settlement; (E) the amount of noneconomic damages, as defined in section 52-572h, or the insurer's estimate of the amount in the event of a settlement; (F) the amount of any interest awarded due to the failure to accept an offer of judgment or compromise; (G) the amount of any remittitur or additur; (H) the amount of final judgment after remittitur or additur; (I) the amount paid by the insurer; (J) the amount paid by the defendant due to a deductible or a judgment or settlement in excess of policy limits; (K) the amount paid by other insurers; (L) the amount paid by other defendants; (M) whether a structured settlement was used; (N) the expense assigned to and recorded with the claim, including, but not limited to, defense and investigation costs, but not including the actual claim payment; and (O) any other information the commissioner determines to be necessary to regulate the professional liability insurance industry with respect to **[**physicians, surgeons, hospitals, advanced practice registered nurses or physician assistants**]** medical

professionals or hospitals, ensure the industry's solvency and ensure that such liability insurance is available and affordable.

(d) (1) The commissioner shall establish an electronic database composed of closed claim reports filed pursuant to this section.

(2) The commissioner shall compile the data included in individual closed claim reports into an aggregated summary format and shall prepare a written annual report of the summary data. The report shall provide an analysis of closed claim information including a minimum of five years of comparative data, when available, trends in frequency and severity of claims, itemization of damages, timeliness of the claims process, and any other descriptive or analytical information that would assist in interpreting the trends in closed claims.

(3) The annual report shall include a summary of rate filings for professional liability insurance for **[**physicians, surgeons, hospitals, advanced practice registered nurses and physician assistants**]** medical professionals or hospitals, which have been approved by the department for the prior calendar year, including an analysis of the trend of direct losses, incurred losses, earned premiums and investment income as compared to prior years. The report shall include base premiums charged by insurers for each specialty and the number of providers insured by specialty for each insurer.

(4) Not later than March 15, 2007, and annually thereafter, the commissioner shall submit the annual report to the joint standing committee of the General Assembly having cognizance of matters relating to insurance in accordance with section 11-4a. The commissioner shall also (A) make the report available to the public, (B) post the report on its Internet site, and (C) provide public access to the contents of the electronic database after the commissioner establishes that the names and other individually identifiable information about the claimant and practitioner have been removed.

(e) The Insurance Commissioner shall provide the Commissioner of Public Health with electronic access to all information received

pursuant to this section. The Commissioner of Public Health shall maintain the confidentiality of such information in the same manner and to the same extent as required for the Insurance Commissioner.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*October 1, 2007*	38a-395

INS *Joint Favorable Subst.*

The following fiscal impact statement and bill analysis are prepared for the benefit of members of the General Assembly, solely for the purpose of information, summarization, and explanation, and do not represent the intent of the General Assembly or either chamber thereof for any purpose:

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 08 $	FY 09 $
Insurance Dept.	IF - Cost	67,000	44,000

Note: IF=Insurance Fund

Municipal Impact: None

Explanation

This bill would create the need for a .5 FTE[1] examiner position to help maintain and manage the expanded medical malpractice database and correspond with affected parties. The need for an additional staff resource also arises from the addition of medical professionals to the group that is required to submit data to the closed claim database.

A one-time cost of $25,000 is included in FY 08, which would be used to hire an outside consultant to perform the modifications necessary to include medical professionals in the Insurance Department's database.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation.

[1] Full-Time Equivalent

OLR Bill Analysis

sSB 249

AN ACT CONCERNING MEDICAL MALPRACTICE DATA REGARDING MEDICAL PROFESSIONALS.

SUMMARY:

This bill requires insurers of any "medical professional," instead of just insurers of physicians, surgeons, advanced practice registered nurses, or physician assistants, to provide to the insurance commissioner a closed claim report, on such form as the commissioner prescribes. A "closed claim" is a claim that has been settled, or otherwise disposed of, and the insurer has paid all claims. By law, the insurer must submit the report within 10 days after the last day of the calendar quarter in which a claim is closed. The report includes information only about claims settled under Connecticut law.

The bill defines "medical professional" as any person licensed or certified to provide health care services to individuals, including chiropractors, clinical dietitians, clinical psychologists, dentists, nurses, occupational therapists, optometrists, pharmacists, physical therapists, physicians, podiatrists, psychiatric social workers, and speech therapists. By law, a closed claim report contains details about the insured and the insurer, the injury or loss, the claims process, and the amount paid on each claim.

EFFECTIVE DATE: October 1, 2007

BACKGROUND

Closed Claim Reports

By law, the insurance commissioner must aggregate the individual closed claim report data into a summary and annual report. The summary must include an analysis of the trend of direct losses,

incurred losses, earned premiums, and investment income as compared to prior years. The report must also include base premiums medical malpractice insurers charge for each specialty and the number of providers insured by specialty for each insurer. By law, the commissioner must annually submit the report to the Insurance and Real Estate Committee. She must also (1) make the report available to the public, (2) post it on the department's Internet site, and (3) provide public access to the contents of the electronic database after establishing that the names and other individually identifiable information about claimants and practitioners have been removed.

Details about the Insured and Insurer

The report must include the (1) insurer's name; (2) policy limits; (3) insured's name, address, license number, and specialty coverage; and (4) insured's policy number and unique claim number. It must also indicate whether the policy was an occurrence policy or was issued on a claims-made basis. An "occurrence policy" provides protection for malpractice that occurred during the time the policy was in effect. A "claims-made" policy provides protection for claims made during the period the policy is in effect.

Details About the Injury or Loss

The report must specify the:

1. date of the injury or loss that was the basis of the claim;

2. date the injury or loss was reported to the insurer;

3. name of the institution or location where the injury or loss occurred;

4. type of injury or loss, including an injury severity rating that corresponds with the injury scale that the commissioner must establish based on the severity scale developed by the National Association of Insurance Commissioners; and

5. name, age, and gender of any injured person covered by the

claim.

Any individually identifiable health information (as defined by federal HIPAA regulation) is confidential. The act specifies that the law requires reporting of this information. It requires that if necessary to comply with federal privacy laws, the insured must arrange with the insurer to release the required information.

Details About the Claims Process

The report must contain details about the claims process including:

1. whether a lawsuit was filed and, if so, in which court;
2. its outcome;
3. the number of other defendants, if any;
4. the stage in the process when the claim was closed;
5. the trial dates;
6. the date of any judgment or settlement;
7. whether an appeal was filed and, if so, the date filed;
8. the resolution of the appeal and the date it was decided;
9. the date the claim was closed; and
10. the initial and final indemnity and expense reserve for the claim.

Details About the Amount Paid on the Claim

The report must include:

1. the total amount of the initial judgment rendered by a jury or awarded by the court;
2. the total amount of the settlement if no judgment was rendered or awarded or the claim was settled after judgment was

rendered or awarded;

3. the amount of economic and noneconomic damages, or the insurer's estimate of these amounts in a settlement;

4. the amount of any interest awarded due to failure to accept an offer of compromise;

5. the amount of any reduction or addition and the amount of final judgment after such reductions or additions;

6. the amount the insurer paid;

7. the amount the defendant paid due to a deductible or a judgment or settlement in excess of policy limits;

8. the amount other insurers or defendants paid;

9. whether a structured settlement was used;

10. the expense assigned to and recorded with the claim, including defense and investigation costs but not including the actual claim payment; and

11. any other information the commissioner determines necessary to regulate the medical malpractice insurance industry, ensure its solvency, and ensure that such liability insurance is available and affordable.

Annual Data Summary

The report must analyze the closed claim information, including:

1. a minimum of five years of comparative data, when available;

2. trends in frequency and severity of claims;

3. itemization of damages;

4. timeliness of the claims process; and

5. any other descriptive or analytical information that would help interpret the trends in closed claims.

The annual report must summarize rate filings for medical malpractice insurance for medical professionals and entities that the department approved for the prior calendar year.

Beginning March 15, 2007, the insurance commissioner must provide the DPH commissioner with electronic access to all the closed case information she receives. The bill also requires the DPH commissioner to keep such information as confidential as the law requires the insurance commissioner to do.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute
Yea 18 Nay 1 (03/13/2007)